a time and manner determined by the U.S. Office of Personnel Management.

(b) *Use of plain language.* The Exchange must determine whether the information required to be submitted and made available under paragraph (a) of this section is provided in plain language.

(c) *Transparency of cost-sharing information.* The Exchange must monitor whether a QHP issuer has made cost-sharing information available in a timely manner upon the request of an individual as required by §156.220(d) of this subtitle.

§155.1045 Accreditation timeline.

The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by §156.275 of this subtitle, except for multi-State plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-State plans.

§155.1050 Establishment of Exchange network adequacy standards.

(a) An Exchange must ensure that the provider network of each QHP meets the standards specified in §156.230 of this subtitle, except for multi-State plans.

(b) The U.S. Office of Personnel Management will ensure compliance with the standards specified in §156.230 of this subtitle for multi-State plans.

(c) A QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider designated under §156.235(c) of this subtitle.

§155.1055 Service area of a QHP.

The Exchange must have a process to establish or evaluate the service areas of QHPs to ensure such service areas meet the following minimum criteria:

(a) The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.

(b) The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

§155.1065 Stand-alone dental plans.

(a) *General requirements.* The Exchange must allow the offering of a limited scope dental benefits plan through the Exchange, if—

(1) The plan meets the requirements of section 9832(c)(2)(A) of the Code and 2791(c)(2)(A) of the PHS Act; and

(2) The plan covers at least the pediatric dental essential health benefit as defined in section 1302(b)(1)(J) of the Affordable Care Act, provided that, with respect to this benefit, the plan satisfies the requirements of section 2711 of the PHS Act; and

(3) The plan and issuer of such plan meets QHP certification standards, including §155.1020(c), except for any certification requirement that cannot be met because the plan covers only the benefits described in paragraph (a)(2) of this section.

(b) *Offering options.* The Exchange may allow the dental plan to be offered—

(1) As a stand-alone dental plan; or

(2) In conjunction with a QHP.

(c) *Sufficient capacity.* An Exchange must consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage.

(d) *QHP Certification standards.* If a plan described in paragraph (a) of this section is offered through an Exchange, another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act.

§155.1075 Recertification of QHPs.

(a) *Recertification process.* Except with respect to multi-State plans and CO–OP QHPs, an Exchange must establish a process for recertification of QHPs that, at a minimum, includes a review

of the general certification criteria as outlined in §155.1000(c). Upon determining the recertification status of a QHP, the Exchange must notify the QHP issuer.

(b) *Timing*. The Exchange must complete the QHP recertification process on or before September 15 of the applicable calendar year.

§155.1080 Decertification of QHPs.

(a) *Definition*. The following definition applies to this section:

Decertification means the termination by the Exchange of the certification status and offering of a QHP.

(b) *Decertification process*. Except with respect to multi-State plans and CO–OP QHPs, the Exchange must establish a process for the decertification of QHPs, which, at a minimum, meets the requirements in this section.

(c) *Decertification by the Exchange*. The Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in §155.1000(c).

(d) *Appeal of decertification*. The Exchange must establish a process for the appeal of a decertification of a QHP.

(e) *Notice of decertification*. Upon decertification of a QHP, the Exchange must provide notice of decertification to all affected parties, including:

(1) The QHP issuer;

(2) Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in §155.420;

(3) HHS; and

(4) The State department of insurance.

[77 FR 18467, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012]

Subparts L–M [Reserved]

Subpart N—State Flexibility

§155.1300 Basis and purpose.

(a) *Statutory basis*. This subpart implements provisions of section 1332 of the Affordable Care Act, relating to Waivers for State Innovation, which the Secretary may authorize for plan years beginning on or after January 1, 2017. Section 1332 of the Affordable Care Act requires the Secretary to issue regulations that provide for all of the following:

(1) A process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input.

(2) A process for the submission of an application that ensures the disclosure of all of the following:

(i) The provisions of law that the State involved seeks to waive.

(ii) The specific plans of the State to ensure that the waiver will meet all requirements specified in section 1332.

(3) A process for the provision of public notice and comment after a waiver application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance.

(4) A process for the submission of reports to the Secretary by a State relating to the implementation of a waiver.

(5) A process for the periodic evaluation by the Secretary of programs under waivers.

(b) *Purpose*. This subpart sets forth certain procedural requirements for Waivers for State Innovation under section 1332 of the Affordable Care Act.

§155.1302 Coordinated waiver process.

(a) *Coordination with applications for waivers under other Federal laws*. A State may submit a single application to the Secretary for a waiver under section 1332 of the Affordable Care Act and a waiver under one or more of the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Act, or under any other Federal law relating to the provision of health care items or services, provided that such application is consistent with the procedures described in this part, the procedures for demonstrations under section 1115 of the Act, if applicable, and the procedures under any other applicable Federal law under which the State seeks a waiver.